

FILED  
HARRISBURG, PA  
MAR 22 2017  
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AO 240 (Rev. 06-09) Application to Proceed in District Court Without Prepaying Fees or Costs (Short Form)

## UNITED STATES DISTRICT COURT

for the

Middle District of Pennsylvania

WELLNESS York Hospital  
Community Health (Dr. Gain And  
Plaintiff (Dr. Chrostka/NINUC DC.  
DR. McCracken )  
Jody K. Butts )  
Defendant )

Civil Action No. 1:17-CV-503

**APPLICATION TO PROCEED IN DISTRICT COURT WITHOUT PREPAYING FEES OR COSTS**  
(Short Form)

I am a plaintiff or petitioner in this case and declare that I am unable to pay the costs of these proceedings and that I am entitled to the relief requested.

In support of this application, I answer the following questions under penalty of perjury:

1. *If incarcerated.* I am being held at: NO (Dr. McCracken) (administrator) recording (3/21/2017)  
If employed there, or have an account in the institution, I have attached to this document a statement certified by the appropriate institutional officer showing all receipts, expenditures, and balances during the last six months for any institutional account in my name. I am also submitting a similar statement from any other institution where I was incarcerated during the last six months. NEVER Complied with, DR. Shaul, Specialist Emily; or DR. Mason.  
2. *If not incarcerated.* If I am employed, my employer's name and address are: (Pro-hono Attorney)

SSI 753.00  
My gross pay or wages are: \$ 753.00 months, and my take-home pay or wages are: \$ N/A per  
(specify pay period)

3. *Other Income.* In the past 12 months, I have received income from the following sources (check all that apply):

- |  |   |                             |
|--|---|-----------------------------|
| (a) Business, profession, or other self-employment | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| (b) Rent payments, interest, or dividends          | <input type="checkbox"/> Yes            | <input type="checkbox"/> No |
| (c) Pension, annuity, or life insurance payments   | <input type="checkbox"/> Yes            | <input type="checkbox"/> No |
| (d) Disability, or worker's compensation payments  | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| (e) Gifts, or inheritances                         | <input type="checkbox"/> Yes            | <input type="checkbox"/> No |
| (f) Any other sources                              | <input type="checkbox"/> Yes            | <input type="checkbox"/> No |

If you answered "Yes" to any question above, describe below or on separate pages each source of money and state the amount that you received and what you expect to receive in the future.

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4. Amount of money that I have in cash or in a checking or savings account: \$ 198.00

5. Any automobile, real estate, stock, bond, security, trust, jewelry, art work, or other financial instrument or thing of value that I own, including any item of value held in someone else's name (describe the property and its approximate value):

NONE (DR. McCracken) talk to one 3-21-2017, He had several people on phone, and recording in room, he talk to fast about 2 months of pills, they took me off, And, I ask about being sent to Apple Hill. prescription, and prescription for my Walker. (That Dr. Christen/Hivas, leaving sick from NOT sending release forms.

6. Any housing, transportation, utilities, or loan payments, or other regular monthly expenses (describe and provide the amount of the monthly expense):

(I'd like. Transit Bus, takes me to Doctors, Hershey PA. (the recording) York, PA. (717) 846-7433 - mobile, come, need transportation help. And know who last 2- yrs. all was in room (Discriminatory Acts, Against me,

7. Names (or, if under 18, initials only) of all persons who are dependent on me for support, my relationship with each person, and how much I contribute to their support:

(Son) Home Health Care, Mark A Martin  
Going thru Agcy and Agency Program. Put a Attach letter - Head.

8. Any debts or financial obligations (describe the amounts owed and to whom they are payable): (Working thru) thier Program to take care of my disabilities.

Declaration: I declare under penalty of perjury that the above information is true and understand that a false statement may result in a dismissal of my claims.

yes

Date: 3/21/2017

Jody K. Butts

Applicant's signature

Jody K. Butts

Printed name

PO: Amy AGING-AGENCY (Home Health Care)

(To whom May Concern) DR. Mark W. Mason  
(Jody K. Butts.) (DR. SHaul  
Specialist: Emily)

(I'm giving Consent) for my oldest Son:  
(Mark A. Martin) to take care of me, with  
(my Disability, with) (Hershey Medical)  
30 Hope Drive.  
(Health care worker) (Hershey, Medical info-  
ra. (mation)

(with Extra) Radiology, laboratory visits.  
Office Visits, Medical Records, medications, CDS  
any treatments. (Health information; medical assistant  
(Release of my Information (Laboratory  
(with Mason, MD Mark W. / DR. SHaul)  
Penn State Hershey Medical Group, Bone and  
Joint Institute, 30 Hope Drive, Suite 2400, Entrar.  
B, Hershey PA. 17033 (717) 531-5638

DR. Kristina / YH CHC NIVUS DO (717) 851-235  
WS. Community Health CTR  
605 S. George St.

(Family Doctor) Release of Information/Health ca  
Provider) My Son) Mark A. Martin / release of  
information / Records / medical / medication / Disability  
of my Health. / Any Portal Information on Records

Given to Penn State Health  
on 2/24/17 (CB)

Thank you, kindly  
Jody K. Butts

Re: Any AGING - AGENCY (Home Health Care)

(To whom May Concern) DR. Mark W. Mason  
(Jody K. Butts) (DR. SHAUL  
Specialist: Emily)

(I'm giving Consent) For my Oldest Son:  
(Mark A. Martin) to take care of me, with  
(my Disability, with) (Hershey Medical)  
(Health care worker) (30 Hope Drive:  
(Hershey, Medical info -  
Pa. (motion)

(with Extra) Radiology, laboratory visits.  
Office Visits, medical Records, medications, CDs,  
any treatments. (Health information; medical assistants  
(Release of my Information (Laboratory  
(with Mason, MD Mark W. / DR. SHAUL) visits)  
(Penn State Hershey Medical Group, Bone and  
Joint Institute, 30 Hope Drive, Suite 2400, Entrance  
B, Hershey PA. 17033 (717) 531-5638

DR. Kristina / YHCHC NIVUS DO (717) 851-2334  
WS. Community Health CTR  
605 S. George St.

(Family Doctor) Release of Information/Health care  
Provider) My Son) Mark A. Martin / release of  
information) Records / medical / medication / Disability  
of my Health. / ANY Portal Information on Records

Thank you, kindly  
Jody K. Butts